

		FOR OHF USE					

LL 1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0019976</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>The Henry and Jane Vonderlieth Living Center, Inc.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1120 North Topper Drive</u> <u>Mt. Pulaski</u> <u>62548</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Logan</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Cindy Russell</u> (Title) <u>Administrator</u>	
Telephone Number: <u>(217) 792-3218</u> Fax # <u>(217) 792-3210</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Helen M. Meagher, C.P.A.</u> (Firm Name & Address) <u>Helen M. Meagher, C.P.A.</u> <u>101 1/2 S. Kickapoo, Lincoln, IL 62656</u> (Telephone) <u>(217) 735-2549</u> Fax # <u>(217) 732-8315</u>	
IDPA ID Number: <u>37-0967671001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>10/21/1973</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Trust		<input type="checkbox"/> Individual	
IRS Exemption Code <u>501 © (3)</u>		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>Helen M. Meagher</u> Telephone Number: <u>(217) 735-2549</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc.# 0019976 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>28</u>			<u>28</u>	8
9	SNF/PED					9
10	ICF	<u>12,454</u>	<u>15,355</u>		<u>27,809</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,482</u>	<u>15,355</u>		<u>27,837</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.74%

D. How many bed-hold days during this year were paid by Public Aid?

9 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 10/21/1973

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 90 and days of care provided 916Medicare Intermediary Mutual of Omaha Medicare

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cent

0019976

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	236,836	16,987	7,906	261,729	(35,689)	226,040		226,040			1
2	Food Purchase		181,624		181,624	(33,949)	147,675	(7,491)	140,184			2
3	Housekeeping	66,598	21,310		87,908		87,908		87,908			3
4	Laundry	44,555	12,188		56,743		56,743		56,743			4
5	Heat and Other Utilities			102,167	102,167		102,167	(5,750)	96,417			5
6	Maintenance	68,293	17,716	27,587	113,596	2,012	115,608	3,447	119,055			6
7	Other (specify):* SEE PAGE 24			2,643	2,643		2,643		2,643			7
8	TOTAL General Services	416,282	249,825	140,303	806,410	(67,626)	738,784	(9,794)	728,990			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,314,897	77,021	4,555	1,396,473		1,396,473		1,396,473			10
10a	Therapy	34,430		148,012	182,442		182,442		182,442			10a
11	Activities	39,685	3,872	562	44,119		44,119		44,119			11
12	Social Services	23,492		3,757	27,249		27,249		27,249			12
13	Nurse Aide Training			819	819		819		819			13
14	Program Transportation			1,488	1,488		1,488		1,488			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,412,504	80,893	159,193	1,652,590		1,652,590		1,652,590			16
	C. General Administration											
17	Administrative	60,697		2,798	63,495	(2,029)	61,466	(560)	60,906			17
18	Directors Fees			3,412	3,412		3,412		3,412			18
19	Professional Services			25,941	25,941		25,941		25,941			19
20	Dues, Fees, Subscriptions & Promotions			15,247	15,247	444	15,691	(47)	15,644			20
21	Clerical & General Office Expenses	73,528	8,626	13,451	95,605		95,605		95,605			21
22	Employee Benefits & Payroll Taxes			328,397	328,397	69,211	397,608		397,608			22
23	Inservice Training & Education											23
24	Travel and Seminar			886	886		886		886			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,318	78,318		78,318		78,318			26
27	Other (specify):*			4	4		4	(4)				27
28	TOTAL General Administration	134,225	8,626	468,454	611,305	67,626	678,931	(611)	678,320			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,963,011	339,344	767,950	3,070,305		3,070,305	(10,405)	3,059,900			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

The Henry and Jane Vonderlieth Living Center, Inc.

#0019976

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			209,919	209,919	(46,523)	163,396	6,429	169,825			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119	119		119	(119)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			210,038	210,038	(46,523)	163,515	6,310	169,825			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,641	995	25,636		25,636		25,636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):* SEE PAGE 24		594	17,174	17,768	46,523	64,291	(64,291)				43
44	TOTAL Special Cost Centers		25,235	67,444	92,679	46,523	139,202	(64,291)	74,911			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,963,011	364,579	1,045,432	3,373,022		3,373,022	(68,386)	3,304,636			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc.

0019976

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,491)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,750)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,429	30		9
10	Interest and Other Investment Income	(119)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4)	27		24
25	Fund Raising, Advertising and Promotional	(27)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(61,404)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,386)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (68,386)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

The Henry and Jane Vonderlieth Living Center, Inc.

ID# 0019976

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Write off prior years deferred maintenance	\$ 5,801	6	1
2	Apartment expenses	(64,291)	43	2
3	Flowers	(535)	17	3
4	Investment expense	(25)	17	4
5	Current year deferred maintenance	(2,354)	6	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(61,404)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc.

0019976

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,491)	0	0	0	0	0	0	0	0	0	0	(7,491)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,750)	0	0	0	0	0	0	0	0	0	0	(5,750)	5
6	Maintenance	3,447	0	0	0	0	0	0	0	0	0	0	3,447	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,794)	0	0	0	0	0	0	0	0	0	0	(9,794)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(560)	0	0	0	0	0	0	0	0	0	0	(560)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(47)	0	0	0	0	0	0	0	0	0	0	(47)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4)	0	0	0	0	0	0	0	0	0	0	(4)	27
28	TOTAL General Administration	(611)	0	0	0	0	0	0	0	0	0	0	(611)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,405)	0	0	0	0	0	0	0	0	0	0	(10,405)	29

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc.# 0019976

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cer # 0019976 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Farmer's Bank of Mt. Pulaski		x	Working capital	None	2/20/3	20,000	None	2/20/04	0.0600	82	6	
7	Farmer's Bank of Mt. Pulaski		x	Working capital	None	4/3/03	16,000	None	4/3/04	0.0600	37	7	
8												8	
9	TOTAL Facility Related						\$ 36,000	\$				\$ 119	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 36,000	\$				\$ 119	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **The Henry and Jane Vonderlieth Living Center, Inc.**# **0019976** Report Period Beginning: **01/01/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.			\$ None	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$ #VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ #VALUE!	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	8		
	1999	9		
	2000	10		
	2001	11		
	2002	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Henry and Jane Vonderlieth Living Center, Inc. COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0019976

CONTACT PERSON REGARDING THIS REPORT Cindy Russell

TELEPHONE (217) 792-3218 FAX #: (217) 792-3210

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>N/A - tax exempt</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:
 37,140

B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

25 apartments owned by corporation

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building and grounds	2,163,000	1971	\$ 55,924	1
2					2
3	TOTALS	2,163,000		\$ 55,924	3

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc.

0019976

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	60		1973	1973	\$ 1,172,276	\$ 29,307	35	\$ 33,494	\$ 4,187	\$ 965,215	4
5	30		1977	1977	441,636	11,041	35	12,618	1,577	328,857	5
6											6
7											7
8											8
	Improvement Type**										
9	Heating system		1979	1979	3,848		20			3,848	9
10	Conversion		1979	1979	11,345	344	33	344		8,422	10
11	Medicine room		1981	1981	474		20			474	11
12	Fence		1981	1981	921		8			921	12
13	Sidewalks		1981	1981	1,209		20			1,209	13
14	Shower room		1982	1982	1,175	34	35	34		728	14
15	Blacktopping		1983	1983	5,095	165	20	165		5,095	15
16	Landscaping		1984	1984	1,000		10			1,000	16
17	Remodeling		1984	1984	3,117	156	20	156		3,055	17
18	Parking lot		1985	1985	36,890		15			36,890	18
19	Fire hydrant		1985	1985	1,308		15			1,308	19
20	Building improvement		1985	1985	5,201	173	30	173		3,178	20
21	Energy management system		1985	1985	9,381	470	20	470		8,569	21
22	Blacktopping		1986	1986	3,885	194	20	194		3,379	22
23	Shrubs		1986	1986	583		10			583	23
24	Sewer lift station		1986	1986	40,129	2,006	20	2,006		34,269	24
25	Sewer lift station		1987	1987	15,420	771	20	771		13,043	25
26	Windows improvements		1988	1988	4,721		5			4,721	26
27	Fan		1988	1988	1,743		5			1,743	27
28	Office remodeling		1988	1988	1,580	4	15		(4)		28
29	Sealcoating		1989	1989	4,580	305	10		(305)	4,580	29
30	Patio door		1990	1990	985	66	15	66		869	30
31	Trees		1990	1990	700		10			700	31
32	Air conditioner		1991	1991	53,731	3,582	15	3,582		45,074	32
33	Building improvements (ceilings, lift station, temperature controls)		1991	1991	16,133		10			16,133	33
34	Building improvements (kitchen floor, sprinklers, fire doors)		1991	1991	43,767	2,918	15	2,918		36,864	34
35	Fire alarm panels		1992	1992	4,622	308	15	308		3,645	35
36	Water softener		1992	1992	7,887		10			7,887	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc.

0019976

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Walk-in cooler	1992	\$ 12,469	\$ 623	20	\$ 623		\$ 6,905		37
38	Door monitor system	1992	1,700		10			1,700		38
39	30 Heating units	1992	9,810	491	20	491		5,769		39
40	Blacktopping	1992	2,859		10			2,859		40
41	Library paneling	1993	3,900	195	20	195		2,064		41
42	Convection units	1993	3,270	164	20	164		1,749		42
43	Asphalt sealcoating	1994	2,809		5			2,809		43
44	Computer room - drywall	1994	2,244	224	10	224		2,147		44
45	Pump	1994	3,439	344	10	344		3,067		45
46	Roof	1995	324,374	12,975	25	12,975		115,493		46
47	Room size heater	1995	1,604	160	10	160		1,427		47
48	Heating system units	1995	9,772	977	20	489	(488)	4,238		48
49	Garage doors	1996	1,550	155	10	155		1,150		49
50	80 Gallon water heater	1996	7,611	761	10	761		5,581		50
51	Exhaust fan	1997	1,691	169	10	169		1,014		51
52	Therapy, activity, administration offices, and additional storage	1998	796,976	22,770	35	22,770		130,928		52
53	Additional finish costs (line 52 above)	1998	4,715	135	35	135		776		53
54	Dampers and motor actuator	1998	3,293	165	20	165		976		54
55	Chiller	1998	14,853	743	20	743		4,396		55
56	Moveable wall	1998	9,830	393	25	393		2,063		56
57	Boiler programmer	1998	2,570	129	20	129		763		57
58	80 Gallon water heater	1998	5,287	529	10	529		3,042		58
59	Chain link fence	1999	1,019	68	15	68		306		59
60	Lowered "one head"	2000	2,087	209	10	209		714		60
61	8 Steel universal access doors 24"x24"	2000	437	44	10	44		150		61
62	11 Smoke & fire dampers	2000	21,450	2,145	10	2,145		6,793		62
63	Card zone expander installed	2000	3,185	319	10	319		1,010		63
64	Floor tile for center corridor & dining room	2000	6,290	419	15	419		1,283		64
65	Blacktopping drive (from def maint per IDPH review 2000 report)	2000	7,309		5	1,462	1,462	2,924		65
66	Boiler	2001	64,480	3,224	20	3,224		6,985		66
67	4" wall base in corridors & dining room	2001	19,200	1,280	15	1,280		2,667		67
68	12 time delayed locks on outside doors	2002	23,618	2,362	10	2,362		3,149		68
69	Boiler room hollow steel door	2002	1,233	35	35	35		64		69
70	TOTAL (lines 4 thru 69)		\$ 3,272,276	\$ 104,051		\$ 110,480	\$ 6,429	\$ 1,869,220		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,272,276	\$ 104,051		\$ 110,480	\$ 6,429	\$ 1,869,220	1
2	Garage	2002	71,872	2,053	35	2,053		2,207	2
3	Driveway entrance sign	2003	1,967	44	15	44		44	3
4	West chain link fence 800'	2003	6,800	113	15	113		113	4
5	Compressor for chiller	2003	7,126	178	10	178		178	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,360,041	\$ 106,439		\$ 112,868	\$ 6,429	\$ 1,871,762	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 457,111	\$ 43,101	\$ 43,101	\$	5-15 yrs	\$ 296,255	71
72	Current Year Purchases	23,359	1,048	1,048		5-15 yrs	1,048	72
73	Fully Depreciated Assets	299,156	859	859		5-15 yrs	299,156	73
74								74
75	TOTALS	\$ 779,626	\$ 45,008	\$ 45,008	\$		\$ 596,459	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient transport	2000 Chev. Supreme Bus	1999	\$ 43,000	\$ 7,167	\$ 7,167		6	\$ 30,460	76
77	Patient transport	2002 Olds Silhouette	2001	28,690	4,782	4,782		6	10,759	77
78										78
79										79
80	TOTALS			\$ 71,690	\$ 11,949	\$ 11,949	\$		\$ 41,219	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,267,281	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 163,396	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,825	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,429	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,509,440	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment land improvements	\$ 82,258	\$ 3,457	\$ 53,607	86
87	Apartments	1,419,851	40,660	681,431	87
88	Portraits	6,000			88
89	Equipment	24,689	2,406	13,757	89
90					90
91	TOTALS	\$ 1,532,798	\$ 46,523	\$ 748,795	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

If NO, see instructions.

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> COMMUNITY COLLEGE <input checked="" type="checkbox"/> HOURS PER AIDE <u>6</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	300	\$	300	
2	Books and Supplies		63		63	
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments		355		355	
8	Nurse Aide Competency Tests		101		101	
9	TOTALS	\$	819	\$	819	
10	SUM OF line 9, col. 1 and 2 (e)	\$	819			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a (3)	hrs	\$	1,145	\$ 59,277	\$	1,145	\$ 59,277	1
2	Licensed Speech and Language Development Therapist	10a (3)	hrs		1,041	27,665		1,041	27,665	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a (3)	hrs		1,086	58,093		1,086	58,093	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts		468	24,641		468	24,641	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab services	39(3)				995			995	13
14	TOTAL			\$	3,740	\$ 170,671	\$	3,740	\$ 170,671	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 521,354	\$	1
2	Cash-Patient Deposits	5,745		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	271,468		3
4	Supply Inventory (priced at FIFO cost)	14,721		4
5	Short-Term Investments	2,745,014		5
6	Prepaid Insurance	17,438		6
7	Other Prepaid Expenses	512		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	1,183		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,577,435	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,924		13
14	Buildings, at Historical Cost	4,645,406		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	882,104		16
17	Accumulated Depreciation (book methods)	(3,124,664)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Land Improvements, at Historical Cost</u>	206,573		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,665,343	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,242,778	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 52,904	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,745		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,273		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Patient Care Prepayments</u>	2,265		36
37	<u>Employee Health Insurance Withheld</u>	4,275		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 188,462	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Apartment Resident Deposits</u>	1,249,117		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,249,117	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,437,579	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,805,099	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,242,678	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,526,460	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,526,460	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	278,639	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 278,639	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,805,099	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc # 0019976 Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,015,203	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,015,203	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,468	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,468	23
D. Non-Operating Revenue			
24	Contributions	295,410	24
25	Interest and Other Investment Income***	72,614	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 368,024	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	25	27
28	SEE PAGE 25	264,941	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 264,966	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,651,661	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	806,410	31
32	Health Care	1,652,590	32
33	General Administration	611,305	33
B. Capital Expense			
34	Ownership	210,038	34
C. Ancillary Expense			
35	Special Cost Centers	43,404	35
36	Provider Participation Fee	49,275	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,373,022	40
41	Income before Income Taxes (line 30 minus line 40)**	278,639	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 278,639	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc.# 0019976Report Period Beginning: 01/01/2003Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,936	2,081	\$ 52,354	\$ 25.16	1
2	Assistant Director of Nursing	1,888	2,083	47,378	22.75	2
3	Registered Nurses	4,547	5,225	103,256	19.76	3
4	Licensed Practical Nurses	24,514	26,445	463,808	17.54	4
5	Nurse Aides & Orderlies	55,525	59,770	585,772	9.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,692	3,059	34,430	11.26	8
9	Activity Director	1,958	2,471	27,538	11.14	9
10	Activity Assistants	1,779	1,915	12,147	6.34	10
11	Social Service Workers	1,843	2,028	23,492	11.58	11
12	Dietician					12
13	Food Service Supervisor	1,731	1,980	22,966	11.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,557	24,755	213,870	8.64	15
16	Dishwashers					16
17	Maintenance Workers	3,907	4,389	68,293	15.56	17
18	Housekeepers	8,204	8,964	66,598	7.43	18
19	Laundry	4,614	5,143	44,555	8.66	19
20	Administrator	2,008	2,081	60,697	29.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,915	2,139	34,169	15.97	23
24	Clerical	3,116	3,274	39,359	12.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,156	5,667	62,329	11.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,890	163,469	\$ 1,963,011 *	\$ 12.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	182	\$ 7,906	1 (3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	41	1,829	10 (3)	38
39	Pharmacist Consultant	12	600	10 (3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	81	10 (3)	43
44	Activity Consultant				44
45	Social Service Consultant	70	3,757	12 (3)	45
46	Other(specify)				46
47	Restorative Program Consultant	23	1,240	10 (3)	47
48					48
49	TOTAL (lines 35 - 48)	329	\$ 15,413		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **The Henry and Jane Vonderlieth Living Center, Inc.**

0019976

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Generator repairs	7/96	\$ 1,528	5	\$ 306	\$ 177	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
2	Water heater mixing brd	1/97	3,892	5	778	780	0	0	0	0	0	0	0
3	Repair chiller	8/97	1,917	5	383	383	225	0	0	0	0	0	0
4	Paint & wallpaper	10/98	3,234	3	1,078	808	0	0	0	0	0	0	0
5	Repair walk-in freezer	9/99	1,746	5	349	349	349	349	234	0	0	0	0
6	Vinyl wall coverings	7/99	14,358	5	2,872	2,872	2,872	2,872	1,434	0	0	0	0
7	Chiller compressor replac	6/00	5,789	5	675	1,158	1,158	1,158	1,158	482	0	0	0
8	Repair chiller	7/02	2,975	5	0	0	248	595	595	595	595	347	0
9	Freezer repairs	6/02	2,369	5	0	0	237	474	474	474	474	236	0
10	Generator circuit load dat	4/03	2,354	5	0	0	0	353	471	471	471	471	117
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 40,162		\$ 6,441	\$ 6,527	\$ 5,089	\$ 5,801	\$ 4,366	\$ 2,022	\$ 1,540	\$ 1,054	\$ 117

Facility Name & ID Number **The Henry and Jane Vonderlieth Living Center, Inc.**

STATE OF ILLINOIS

0019976

Report Period Beginning: **01/01/2003**

Page 23

Ending: **12/31/2003**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL - \$4,596
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,484 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 49,275
This amount is to be recorded on line 42 of Schedule V. _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 69,638 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,468
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. _____
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Helen M. Meagher, C.P.A. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees. _____

[illegible]

Facility/College	Amount
Lincoln Land Community College	\$ 414
Springfield, IL	
New Start, Inc.	405
522 E Monroe, 6th floor	
Springfield, IL	
TOTAL Cost	\$ 819